network health

Network Health Group Medicare Advantage Plans (PPO)

MedicareRx Prescription Drug Coverage

By completing this enrollment application, I agree to the following.

Network Health is a Medicare Advantage plan and has a contract with the Federal government.

I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan.**

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or through my employer group.

Network Health serves a specific service area. If I move out of the area that Network Health serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

Once I am a member of Network Health's Group Medicare Advantage Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (EOC) from Network Health when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. Network Health's Group Medicare Advantage Plans offer worldwide coverage for emergency care.

I understand that beginning on the date Network Health's coverage begins, I must get all of my health care from Network Health, except for emergency or urgently needed services, or out-of-area dialysis services. Services authorized by Network Health and other services contained in my Network Health EOC will be covered. Without authorization, neither Medicare nor Network Health will pay for these services.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Network Health, he/she may be paid based on my enrollment in Network Health Group Medicare Advantage Plans.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **IMPORTANT Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

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Step 1

Employer or Union Name:	**Group Number:**

I would like to enroll in:

- ☐ Network Health Cornerstone (PPO) <**$0**> per month
- ☐ Network Health Cornerstone Ultimate (PPO) <**$100**> per month
- ☐ Network Health Cornerstone Ultimate Plus (PPO) <**$150**> per month

Plan Effective Date
I would like my coverage to begin on:
_____/____/______
(MM / DD / YYYY)

LAST Name:	**FIRST Name**:	**Middle Initial:**

Birth Date:	**Sex**:	**Home Phone Number**:	**Alternate Phone Number**:
(____/____/________) (MM / DD / YYYY)	☐ Male ☐ Female	( )	( )

Permanent Residence Street Address (Don't enter a PO Box):

City:	**County**:	**State**:	**Zip Code**:

Mailing Address (only if different from your Permanent Residence Address, PO Box allowed):

Street Address: ____ City: _______________________________

State: _______________ Zip Code: _______________________

Email Address:

Please Provide Your Medicare Insurance Information

Name (as it appears on your Medicare Card):

____

Medicare Number:

____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	_______________
MEDICAL (Part B)	_______________

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

Step 2

Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to a Network Health Medicare Advantage Plan?

☐ Yes ☐ No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of Other Coverage:	ID # for This Coverage:	Group # for This Coverage:
_________________________	______________________	____________________

Step 3

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you the retiree? ☐ Yes ☐ No

☐ Yes – Please indicate your retirement date (____/____/________) (MM / DD / YYYY)

☐ No – Please indicate the complete name of the retiree (First/Last/Middle Initial)_________________________

Network Health Group Medicare Advantage Plans (PPO)

MedicareRx
Prescription Drug Coverage

Are you covering a spouse or dependent(s) under this employer or union plan? (If applying for coverage, spouse will submit their own individual application.)

☐ Yes – Provide the complete name of your spouse (First/Last/Middle Initial)______________________________
☐ Yes – Provide the complete name of your dependent(s) (First/Last/Middle Initial)__________________________
☐ No

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Please provide the name and location of your personal doctor (also referred to as a primary care practitioner or PCP):
____

Please check one of the boxes below if you would prefer us to send you information in an accessible format.
☐ Large print ☐ Braille ☐ Audio CD ☐ Language other than English Language needed ____________________
Please contact Network Health Medicare Advantage Plan at 800-983-7587 (TTY 800-947-3529) if you need information in a language other than English. Our office hours are Monday–Friday, from 8 a.m. to 8 p.m.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
☐ No, not of Hispanic, Latino/a or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Cuban
☐ Yes, Puerto Rican ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ I choose not to answer

What's your race? Select all that apply
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino
☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐Vietnamese ☐ White ☐I choose not to answer

Step 4 IMPORTANT: Please read and sign on the next page

• I must keep both Hospital (Part A) and Medical (Part B) to stay in a Network Health Medicare Advantage Plan.
• By joining this Medicare Advantage Plan, I acknowledge that Network Health Medicare Advantage Plan will share my information with Medicare, who may use it to track my enrollment, to make payments and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
• Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
• The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
• I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
• I understand that when my Network Health Group Medicare Advantage Plan coverage begins, I must get all of my medical and prescription drug benefits from Network Health. Benefits and services provided by Network Health and contained in my Network Health Group Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Network Health Medicare Advantage Plan will pay for benefits or services that are not covered.
• I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
1) This person is authorized under state law to complete this enrollment, and
2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information. Please send the appropriate paperwork showing you are the authorized representative within two weeks of submitting the application.

Name: ____

Address: ____

Phone Number: (_____) ____

Relationship to Enrollee: ____

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____________________________

Agent ID#: _____________________________

Date application was completed with agent/broker: _____________________________

Application left with prospect to mail: ☐ Yes ☐ No

How was enrollment completed: ☐ Telephonic ☐ Virtual ☐ In-Person

Effective Date of Coverage: ______________________

ICEP/IEP: _______ AEP: _______ SEP (type): ______ Not Eligible: _______

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.